U.S. Behavioral Health Plan, California

UNITED BEHAVIORAL HEALTH

Authorization for Release of Information

Member's Name	Birth Date	Member's ID#, SSN, or Chart # (circle one)

Street Address	City	State	Zip Code

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying UBH/USBHPC in writing, but if I do, it will not have any effect on any actions UBH/USBHPC took before it received the revocation.

I hereby authorize United Behavioral Health/USBHPC to (check all that apply):

☐ Exchange with ☐ Release to ☐ Obtain from **the parties I have indicated below**

I hereby authorize United Behavioral Health/USBHPC to exchange / release / obtain information:

☐ verbally only ☐ in written form only ☐ both verbally and in writing

Person/organization receiving/communicating the information:

Name: _____

Address: _____

_____

Phone Number: (_____)_____

Description of individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained:

☐ All
☐ Claims
☐ Eligibility/Benefits
☐ Treatment Plan(s)
☐ Outpatient Progress Reports
☐ Attendance Only
☐ Clinical records used to make benefit determinations (may include HIV/AIDS and/or Substance Abuse information)
☐ All records relating to a Disability claim
☐ All pertinent documentation UBH/USBHPC deems appropriate for the purpose(s) checked below
☐ Other (describe): _____

The purpose of this release is (check all that apply):

☐ To allow the clinically appropriate management and coordination of the Member's mental health and/or substance abuse treatment and/or coverage under the Member's health benefit plan (Care Management and Coordination).
☐ Benefit Management
☐ Claims Administration/Payment
☐ Employer Mandated Treatment Referral
☐ Administration of a Worker's Compensation claim
☐ Administration of a Disability claim
☐ Subpoena or other legal process
☐ To release physical records described above
☐ Other (describe): _____

The dates of records to be disclosed: ***(This section must be completed by Virginia residents*****)**
From ____ / ____ / ____ (MM/DD/YY) To ____ / ____ / ____ (MM/DD/YY)

THE MEMBER OR THE MEMBER'S REPRESENTATIVE MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire :

☐ On ____/____/____ (MM/DD/YY) or one year from the date of the signature below (or as set forth by other applicable federal or state law – see below).

OR

☐ Once the following event occurs **(*does not apply to Illinois residents*)**:
_____

(Form must be completed before signing)

Signature of Member/Legal Guardian or Member's Representative	Signature of Minor Member	Date
Print Name of Member's Representative	Relationship to the Member	Description of Representative's Authority
(For Illinois residents only) Witness Signature		Date of Witness Signature

(*For California and Georgia residents only*)I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

Initials: _____

(*For California and Georgia residents only*) A copy of this form has been requested and received:
_____ Yes _____ No **Initials**: _____ (patient)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

PLEASE NOTE THE FOLLOWING STATE-SPECIFIC PROVISIONS

Arizona: The request must be in writing and signed by the person requesting the medical records. The person requesting the medical records must demonstrate the authority to have access to the records.

California: The patient or the person signing this form has the right to receive a copy of the Consent Form. Authorization terminates upon the earlier termination of policy coverage, or 60 days after the termination of treatment.

Georgia: Advises that the individual, or the individual's authorized representative, is entitled to receive a copy of the authorization form.

Illinois: A witness signature is required. Release must specify expiration date as a calendar date (i.e., month/day/year). If no calendar date is specified, the information may be released only on the day the consent form is received. Must include right to inspect and copy information to be disclosed. Must also include consequences of refusal to consent, if any. Records do not include information regarding HIV/AIDS status without a release that explicitly and specifically includes the release of such information.

Indiana: Expiration of the Release may be a date, event or other condition. If no expiration is specified, the release is valid for 180 days after the date the request was made.

Iowa: The individual has the right to inspect the disclosed information at any time.

Minnesota: Release expires on the earlier of the specific date stated or one year from date signed.

Oregon: Unless revoked earlier, the Release will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

Virginia: To be valid, the Release must state the inclusive dates of the records to be disclosed.

Ohio: Release automatically expires 90 days after the date of the authorization unless an earlier date, event, or condition is specified.

Washington: Release expires on the earlier of the specific date stated or 90 days after signed, including authorization to release future health care information, except information to third party health care payors.

States with no State-Specific Provisions: Missouri, Nebraska, Rhode Island, South Carolina, Tennessee, and Wisconsin.